Billing codes for opioid use disorder related care[1]

The information in this document is applicable for primary care family physicians. Remuneration amounts may vary for those working in a Family Health Organization or Network.

A680 – initial assessment, substance abuse – $144.75

- **When to use:** when a minimum of 50 minutes of personal contact time is spent assessing a patient related to substance abuse with/without patient's relatives/representatives
- **Elements of service must include:**
  - Assessment/diagnosis including a DSM diagnosis for each problematic substance
  - A complete history of illicit drug use, abuse and dependence
  - Patient history including: addiction medicine, past medical, family and psychosocial history (including education)
  - Review of systems
  - A focused physical examination, when indicated
  - Review of treatment options
  - Formulation of a treatment plan
  - Communication with the patient and/or family, support staff from treatment environment and/or previous care providers (including family doctors) as necessary to obtain information for the assessment
- **Limitations:**
  - Doesn't cover time spent rendering other services to the patient
  - Only eligible to the physician intending to subsequently render treatment of the patient's substance abuse
  - Must be pre-booked at least one day before the service is rendered
  - Limited to one per patient per physician (unless 12 month period has elapsed since the most recent insured service rendered to the patient by the same physician)
  - Limited to two per patient per 12 month period (in circumstances where multiple physicians are assessing the patient)
- **Medical record requirements:**
  - Start and stop times of the service must be recorded
  - A DSM diagnosis must be recorded in relation to each problematic substance
  - Relevant information obtained in the provision of the all elements of the service must be recorded

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K680 – extended assessment, substance abuse – $62.75 per unit*

- **When to use:** when providing care to patients receiving therapy for substance abuse
  - Time based service with time calculated based on units; unit = 1⁄2 hour or major part thereof
- **Elements of service must include:**
  - Direct physical encounter with the patient including taking a patient's history and performing a physical examination
  - Other inquiry (including taking a patient history), carried out to arrive at an opinion as to the nature of the patient's condition and/or follow-up care (before, during or after the physical examination)
  - Performing any procedure(s) during the same encounter as the physical examination (except if the procedures are billed separately and an amount is payable for the procedure in conjunction with the therapy or interaction)
  - Making arrangements for follow-up care and any related assessments, procedures, therapy and/or interpreting results
  - Discussing and providing advice and information including prescribing therapy (in-person or over the phone) to the patient or their representative regarding the service and/or results of related procedures and/or assessments (only if professionally appropriate to share results prior to any further patient visits)
  - Monitoring the condition of the patient and intervening (when medically indicated), until the next insured service is rendered
  - Providing premises, equipment, supplies and personnel for the specific elements of the service
- **Limitations:**
  - No other consultation, assessment, visit or time-based service is eligible for payment when rendered the same day as K680 to the same patient by the same physician
- **Medical record requirements:**
  - Start and stop times of the service must be recorded

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Monthly management of a patient in an Opioid Agonist Maintenance Program (OAMP)

K682 – OAMP monthly management fee, intensive, per month – $45.00

K683 – OAMP monthly management fee, maintenance, per month – $38.00

K684 – OAMP monthly management fee, team premium, per month – add $6.00 to K682 or K683

- **When to use:** when providing monthly management and supervision of a patient receiving opioid agonist treatment
- **K682 vs. K683 vs. K684:**
  - K682 is for when two required services (consultation, assessment, visit or K-prefix time-based service) are conducted in the month (via encounter or telemedicine), and K683 is for when one required service is conducted in the month (via encounter or telemedicine)
  - K684 is for when at least one required service (not including urine testing or provision of a prescription) is conducted in the month by a team consisting of the most responsible physician and two non-physician members trained in addictions medicine
- **Elements of service must include:**
  - All medication reviews, adjusting the dose of the opioid agonist therapy, and where appropriate, prescribing additional therapy and dialoguing with pharmacists
  - Discussing and providing advice and information (in-person, over the phone, by fax or email) to the patient or their representative regarding the service (does not include physician to physician telephone consultation services)
  - All discussions regarding the patient's opioid dependency (except where the discussion is payable as a separate service)
- **Limitations:**
  - Does not cover services primarily for the purpose of providing a prescription
  - K682, K683 and K684 are only eligible for payment to the physician most responsible for the patient's OAMP for the applicable month (when the most responsible physician is temporarily absent and/or the patient is transferred to another physician in any month, the physicians should determine who will submit the claim and receive payment for that month; duplicate claims will result in only the first received being paid)
  - K682 is limited to a maximum of six services per patient per 12 month period
  - Limited to a maximum of one of K682 or K683 per patient per month across all physicians
- **Medical record requirements:**
  - For K684, all required patient encounters (with the most responsible physician and two non-physician members) must be documented in the medical record

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K013, K033 – counselling, individual care – $62.75, $38.15 per unit*

- **When to use:** when providing a patient visit dedicated solely to educational dialogue regarding a patient's problems/situation, modalities for prevention, treatment, and/or to provide advice and information in respect of diagnosis, treatment, health maintenance and prevention
    - Time-based service with time calculated based on units; unit = 1⁄2 hour or major part thereof
- **K013 vs. K033:** K013 is for the first three units per patient per physician per 12 month period, and K033 is for additional units (beyond the first three) per patient per physician per 12 month period
- **Elements of service must include:**
    - Performing the appropriate therapy or interaction with the patient, which may include: inquiries (e.g. patient history, brief physical exam) carried out to inform decision-making regarding the patient's condition, any appropriate procedures, related services and/or follow-up care
    - Performing any procedure(s) during the same encounter as the therapy or other interaction (except if the procedures are billed separately and an amount is payable for the procedure in conjunction with the therapy or interaction)
    - Making arrangements for follow-up care and related assessments, procedures or therapy
    - Discussing and providing advice and information including prescribing therapy (in-person or over the phone) to the patient or their representative regarding the service and/or results of related procedures and/or assessments (only if professionally appropriate to share results prior to any further patient visits)
    - Monitoring the condition of the patient and intervening (when medically indicated), until the next insured service is rendered
    - Providing premises, equipment, supplies and personnel for the specific elements of the service
- **Limitations:**
    - Doesn't cover advice given to a patient that would ordinarily constitute part of a consultation, assessment, or other treatment
    - No other services are eligible for payment when rendered by the same physician in the same day as any type of counselling service (exceptions include: E080, G010, G039-43, G202, G205, G365, G372, G384, G385, G394, G462, G480, G482, G489, G538, G590, G840-848, H313, K002, K003, K008, K014, K015, K031, K035, K036, K038, K682-684, K730)
    - Limited to three units per patient per physician per year at the higher fee (K013); beyond that use the lesser fee (K033)
    - Must be pre-booked appointment (or lesser fee will be applied)

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Point of care drug testing

G041, G042 – target drug testing, urine, qualitative or quantitative – $3.70, $2.50 per test

G040, G043 – 4+ drugs of abuse screen, urine – $15.00, $7.50 per test

G039 – creatinine – $1.03 per test

- **When to use:** when a point of care drug test is performed in a physician's own office for the physician's own patient
- **G041 vs G042 vs G040 vs G043:**
  - G041 and G042 are for targeted drug tests
  - G040 and G043 are for tests for specific drugs of abuse including: alcohol, methadone, methadone metabolite, morphine, synthetic or semi-synthetic opiates, cocaine, benzodiazepines, amphetamines, methamphetamines, cannabinoids, barbiturates or any other drug of abuse
  - When K682 or K683 <u>are</u> payable in the month for the same patient – G041 and G040 are for the first five services per patient per month per physician, and G042 and G043 are for additional services (beyond the first five) for up to four additional services per patient per month per physician
  - When K682 or K683 <u>are not</u> payable in the month for the same patient – use G041 and G040
- **Limitations:**
  - When K682 or K683 <u>are</u> payable in the month for the same patient – Limited to five services per patient (any combination) per month to any physician at the higher fees (G041 and G040); beyond that use the lesser fees (G042 and G043) for up to four additional services per patient per month to any physician
  - When K682 or K683 <u>are not</u> payable in the month for the same patient – Any combination of G041, G042, G040 and G043 is limited to a maximum of three services per patient per month for management of a patient with chronic pain or an addiction
  - G040 must include testing for at least four drugs of abuse
  - G041, G042, G040 and G043 are not eligible for payment unless a consultation, assessment, K623, K624 or time-based service involving a direct physical encounter with the patient is payable in the same month to the same physician
  - G039 is limited to a maximum of two tests per patient per week
  - G039 is only eligible for payment when rendered to rule out urine tampering
  - Only one of G041, G042, G040 or G043 is eligible for payment per urine sample
- **Medical record requirements:**
  - Results of the test(s)
  - Physician's interpretation of the results of the test(s)
  - Treatment decision based on the test results

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***Unit =** 1/2 hour or major part thereof. Services are calculated and payable in time units of 30 minute increments. Services less than 20 minutes are not eligible. In calculating the time unit(s), the minimum time required in direct contact with the patient (or their relatives/representatives) and the physician in person is as follows:

# Units	Minimum time with patient
1	20 minutes
2	46 minutes
3	76 minutes (1 hour and 16 minutes)
4	106 minutes (1 hour and 46 minutes)
5	136 minutes (2 hours and 16 minutes)
6	166 minutes (2 hours and 46 minutes)
7	196 minutes (3 hours and 16 minutes)
8	226 minutes (3 hours and 46 minutes)

References:

1. Ministry of Health and Long-Term Care. Schedule of benefits: Physician services under the Health Insurance Act. 2016 [cited 2018 Dec 13]. Available from: http://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master20160401.pdf

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